Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Intravenous (IV) Immune Globulin Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	Zip:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

☐ **New** ☐**Refill** **Ship by:** ____/____/____ **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:**_____

Prescription	Drug	Dose, Directions, & Quantity	Refills
Immune Globulin Products	☐ Flebogamma® 5% ☐ Flebogamma® 10%		
	☐ Gammaked 10% ☐ Gammagard Liquid® 10% ☐ Gammaplex® 5% ☐ Gammaplex® 10% ☐ Gammagard® S/D ☐ Gamunex-C® 10%		
	☐ Octagam® 5% ☐ Octagam® 10%		
	☐ Privigen® 10%		
Other Medications	☐ Acetaminophen		
	☐ Diphenhydramine		
	☐ Heparin		
	☐ Sodium Chloride 0.9% 5-10mL		
	☐ Solu-Cortef®		
	☐ Solu-Medrol®		

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Reason(s) for Discontinuing:
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Diagnosis (ICD-10): _____ **Date of Diagnosis:** _____/_____/_____

IgA Deficiency: ☐ Yes ☐ No **IgA level:** _____mg/dL **Date:**____/____/_____

IgG trough: _____mg/dL **Date:**____/____/_____

Access: ☐ Peripheral ☐ PICC ☐ Implant Port ☐ Broviac®/Hickman®

Allergies:

Additional Clinical Information:

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.